Oct. 15, 2003

Marlene Dortch
Secretary
Federal Communications Commission
445 12th St., S.W.
Washington, D.C. 20554

Re: Ex Parte Presentation in WC Docket 02-60

Dear Madam Secretary:

I am writing to inform you of an ex parte presentation made to Diane Law Hsu and Shannon Lipp of the Wireline Competition Bureau in the permit-but-disclose proceeding, See § 1.1206 of the Commission's Rules, WC Docket 02-60, *In the matter of Rural Health Care Support Mechanism*, Notice of Proposed Rule Making, FCC No. 02-122, released April 19, 2002.

I met with Ms. Hsu and Ms. Lipp on Tuesday, October 14, 2003 for almost an hour. The attached memo summarizes the substance of our conversation. I have also attached materials that were left with the Commission's staff during the course of our conversation.

If there is any additional information needed, please contact my office and we will provide it promptly.

Sincerely,

/s/

Anne E. Linton, Partner

Enclosures
Cc: Diane Law Hsu
Shannon Lipp

MEMORANDUM

To: Marlene Dortch, Secretary, Federal Communications Commission

From: Anne Linton, Partner, Washington Federal Strategies

Re: Ex Parte Presentation in WC Docket 02-60 on Oct. 14, 2003

Date: Oct. 15, 2003

As required under Part 1 of the FCC's Rules, I am filing this memorandum summarizing the oral presentation that I made to Diane Law Hsu and Shannon Lipp of the Wireline Competition Bureau in WC Docket 02-60 on October 14, 2003. I am attaching to this memo the written materials I shared with Ms. Hsu and Ms. Lipp at that meeting.

My client Healthcare Anywhere requested this meeting to present additional information for the Commission's record regarding innovative ways to deliver health care services to underserved people in remote areas such as Native Americans in the Aberdeen Area, and elsewhere.

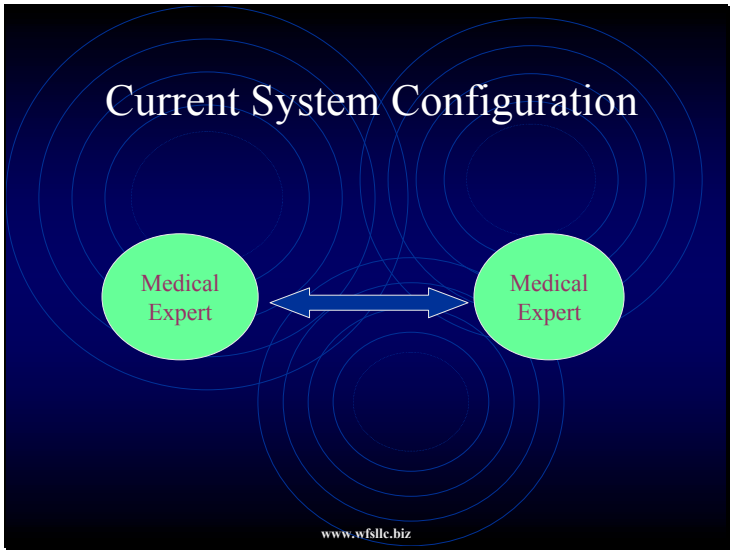
The meeting started with a description of a specific mobile digital telemammography project that Healthcare Anywhere is developing – in conjunction with the Indian Health Service – to deliver high quality, real-time digital mammography services to four Indian tribes in rural North Dakota. Some of the tribes receive health care from the Indian Health Service, a subdivision of the Department of Health and Human Services, but some of the tribes are independent and responsible for their own healthcare delivery. This project will work with both types of tribes. We used this specific project to enter into a discussion of the need for the rural health support mechanism to address functional equivalence between cities and rural areas rather than a service by service comparison. Healthcare Anywhere strongly believes that a functional equivalence approach will be essential to addressing the need to expand the reach of telecommunications services to these underserved areas, and further that functional equivalence is essential to furthering innovation in the ways that we deliver health care to rural areas.

We discussed some other innovative projects that telemedicine has enabled, from insular areas in the US to innovation in post-operative care in Australia, as a way of

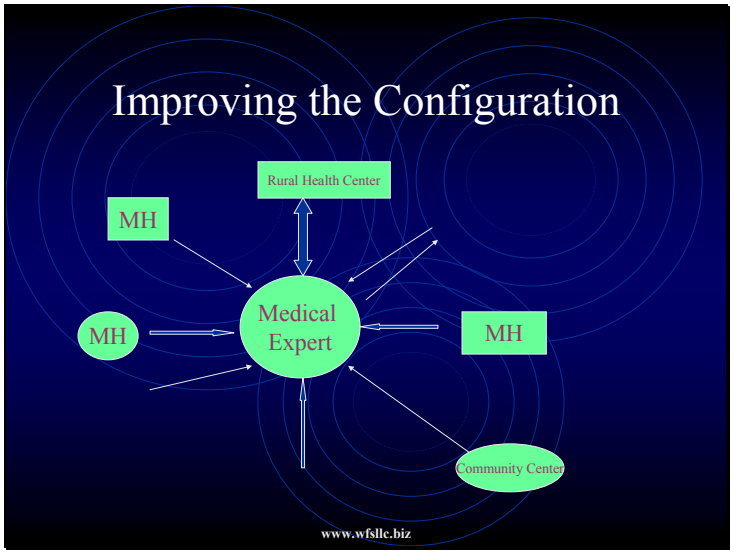
discussing what really can be done when telecommunications services are made available.

Finally, we discussed the fact that the lack of a broad range of telecommunications options has caused the health care field to perceive that real innovation in the delivery of care is not possible because the telecommunications services necessary are unavailable. Healthcare Anywhere urged the Commission to take action in such a way that health care service delivery in underserved rural areas, especially on Indian reservations, be enhanced, and innovation encouraged. We believe this will drive demand for telecom services and provide essential health care to these underserved people.

Slide 1


Current System Configuration
Medical Expert
Medical Expert
www.wfsllc.biz

Slide 2



Better information leads to better decisionmaking and better outcomes!!!!!!!!!!
This is as true in design of networks as it is in providing health care; don't let the systems get designed the old-fashioned way.

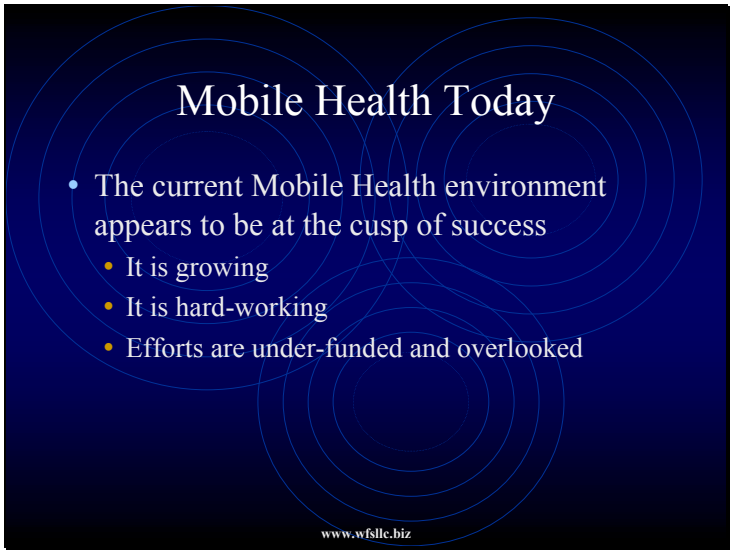
Slide 3

Successes

- IHealthbeat reported on Oct. 3 that a team of burn speicalists in Australia provided follow up care to a burn victim using digital images. The patient returned home much sooner – saving costs for gov't and for family.

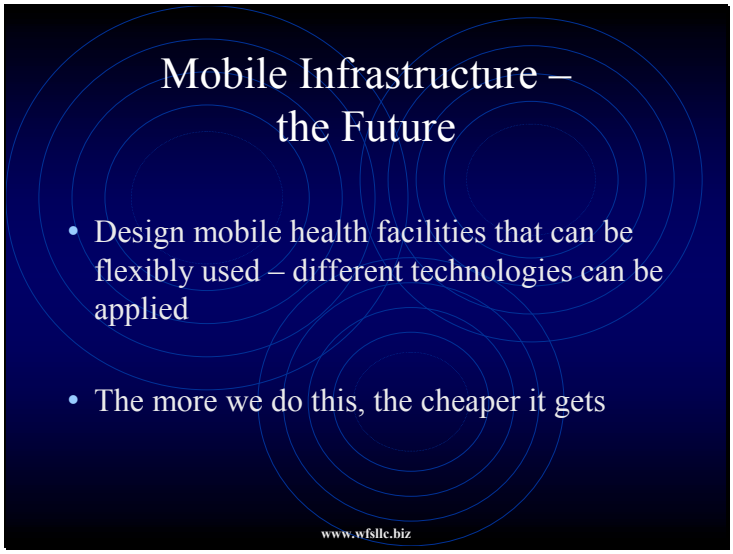
www.wfsllc.biz

Slide 4



Many economic sectors go through this phase: there is lots that just needs to be brought together to start a great growth spurt. I believe that Mobile Health is at that point now. The technology convergence has arrived, but its adoption is not widespread; further, there are entrenched attitudes that pose barriers to the growth we all hope for. As some of those barriers break down, Mobile Health will take off, because it holds the potential to address so MANY of the needs we all see.
Real-time provision of care
Expansion of the reach of best practices and scarce resources
Better cost allocation for technology and people

Slide 5

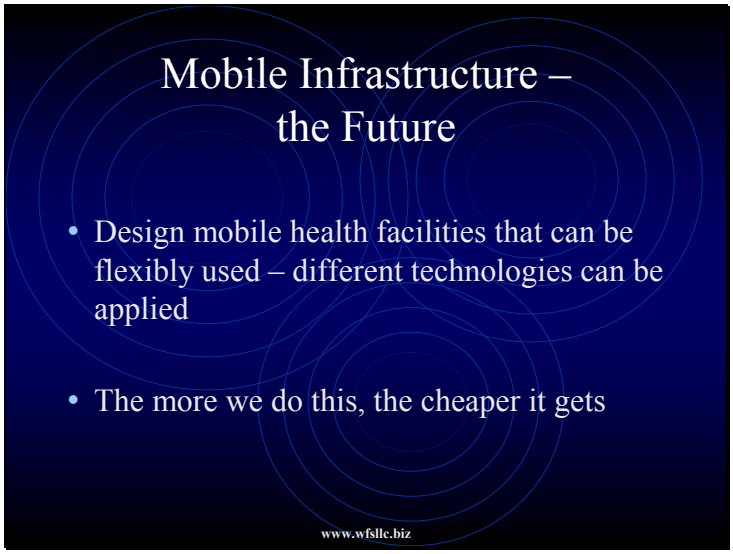


I like to think of what in computer terms is known as plug and play: with Dicom and HL7, you get the telecom and computer processing technology in place, then you add the necessary clinical elements, but in a way that allows easy switching from one need to another, especially if there is an emergency. Can you swap a digital ultrasound out and put a digital microscope in? Can you have a digital retina camera for everyday use, but add on additional capabilities that share the same processing, storage, and transmission facilities?

In the past, telemedicine projects have formed when pockets of providers have had concepts that they wish to explore. That has balkanized some of the telemedicine efforts that are necessary.

Each state is likely to have a central location that might be able to offer excellence. A state university may even have a mandate to back up the efforts of regional and rural healthcare providers. Use those incentives to help drive telemedicine into your mobile health initiatives.

Slide 6



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